

Chapter 13

The Implications of Diversity for Scientific Standards of Practice

Stanley Sue

University of California, Los Angeles

The principle that scientific standards should underlie clinical practice is widely accepted. Nevertheless, as we contemplate the application of scientific standards to practice with diverse populations, a number of important and interesting policy, practice, research, and political issues arise.

1. Research and policy dilemmas: Is there any evidence that psychotherapy is effective with ethnic minority populations? Should we offer psychotherapy even if effectiveness has not been demonstrated? Should policy and practices be strictly guided by research findings? How far do we go in adopting the "whatever works" philosophy? Can standards be culturally biased?
2. Socio-political issues: Is ethnic matching of therapist and client a form of segregation? Should we offer specialized ethnic specific services to targeted groups or should ethnic specific services be avoided? If therapists are not competently trained to work with diverse populations, should their practice be limited?
3. Implications for practice and research: What kinds of therapist or treatment characteristics are associated with effectiveness in the provision of services to ethnic populations? Aside from the need to study growing ethnic minority populations in society, are there good reasons to conduct diversity research? That is, in what ways can diversity research enhance our activities as scientists and practitioners?

In trying to address these questions, I have no magical insights into the solutions. In fact, I shall try to raise questions and draw implications rather than to provide answers. Let me begin by indicating my particular diversity focus. Diversity can obviously be framed in a variety of terms—ethnicity, gender, social class, sexual orientation, or other human characteristics. I shall confine my comments to ethnic minority populations with the assumption that many of the issues that will be mentioned are applicable to other diverse populations. Rather than to spend time trying to define ethnicity, culture, and minority groups, I want to get to the heart of the chapter and address the policy, socio-political, and research issues.

Research and Policy Dilemmas

Empirical Evidence

Is psychotherapy effective with members of ethnic minority groups? The fact of the matter is that there is not much of a scientific base for demonstrating positive treatment outcomes among diverse client populations. The paucity and state of treatment outcome studies on ethnic minorities make it difficult to draw any definitive conclusions about the effectiveness of psychotherapy with ethnic minorities.

Not counting analogue investigations, I know of no studies that meet basic conditions, or even most of the basic conditions, important for demonstrating treatment efficacy—namely, research in which (a) pre- and post treatment outcomes are assessed for clients from one or more ethnic group(s), (b) random assignment and control groups (e.g., no treatment, attention-placebo, or different ethnic groups matched on demographic characteristics other than ethnicity, etc.) are used when appropriate, (c) type of treatment and ethnicity are crossed when comparisons of outcomes by ethnicity and treatment are made, (d) multiple, culturally cross-validated assessment instruments are employed, (e) outcomes are assessed over time, and (f) findings are replicated.

Reviews of the literature on the effectiveness of psychotherapy with ethnic minorities—largely African Americans—have yielded different conclusions. Sattler (1977) generally concluded that African Americans did not differ from Whites in treatment outcomes. On the other hand, Griffith and Jones (1978) believed that evidence indicated that clients' race did have an effect on psychotherapy outcomes. Others took a more moderate position. Parloff, Waskow, and Wolfe (1978) felt that the paucity of treatment outcome studies on African Americans did not permit conclusions to be drawn, a point supported in the reviews by Abramowitz and Murray (1983) and Sue, Zane, and Young (1994). Because reviews of the literature are available, I shall only mention some of the research in passing. Some of my own work are discussed in more detail because policy issues have arisen from them.

Some studies have demonstrated no treatment outcome differences in the case of African American and White clients (Jones, 1978; 1982; Lerner, 1972); high rates of premature termination on the part of ethnic minority clients (Sue, 1977); poorer outcomes among ethnic minorities than Whites in drug treatment programs (Brown, Joe, & Thompson, 1985; Query, 1985); less positive posttreatment change among African American than White clients (Sue, Fujino, Hu, Takeuchi, & Zane, 1991); and more favorable outcomes among treated rather than control groups of Latinos boys (Szapocznik et al., 1989). Conclusions are difficult to draw, given the inconsistencies in the findings from these studies and the fact that researchers examining treatment outcomes for ethnics have had to rely on less-than-rigorous studies, approximations of true outcome studies, theoretical and conceptual arguments, anecdotes and case examples, and research primarily conducted on African Americans.

Cultural Interventions

Rather than to address the broader question of whether psychotherapy is effective, some investigations have examined whether culturally sensitive interventions have an influence on clients. The interventions include improving the accessibility of services to ethnic minorities (e.g. by providing flexible hours, placing the treatment facility in the Latino communities), and employing bicultural/bilingual staff. They may also involve the selection, modification, or development of therapies that consider the cultural customs, values, and beliefs of clients (e.g. involving indigenous healers or religious leaders in the community in treatment, increasing participation of family members in treatment, etc.) Research suggests that these treatment may increase service utilization, length of treatment, client's satisfaction with treatment, and therapy outcomes, and decrease premature termination of treatment (Rogler, Malgady, & Rodriguez, 1989; Sue, Zane, & Young, 1994; Szapocznik et al., 1989).

One study has tried to link changes in the mental health system to utilization and premature termination patterns of ethnic minority clients. O'Sullivan, Peterson, Cox, and Kirkeby (1989) studied the status and situation of ethnic clients in the Seattle mental health system. They noted that the system had made special efforts to hire ethnic providers, create ethnic-specific services, and establish innovative and culturally-consistent treatment modalities. Using some of the same variables reported in an earlier study (Sue, 1977), they found that the situation had improved considerably from that found in the earlier study. Ethnic minority groups for the most part were no longer underutilizing services; their dropout rates had been reduced and were not much different from that of Whites. O'Sullivan and his colleagues attributed the changes to the increasing cultural responsiveness of the system to underserved populations.

The work of O'Sullivan and his colleagues is certainly encouraging, in that our mental health systems have perhaps become more effective and culturally-appropriate for diverse groups. However, their conclusions were based on a temporal relationship: "Culturally-responsive" features were introduced and ethnic minority groups seemed to fare well. Some of our own research (Sue, Fujino, Hu, Takeuchi, & Zane, 1991) was intended to more directly test the association between culturally-responsive strategies and treatment outcomes. Our study was based on thousands of African American, Asian American, Mexican American, and White clients seen in the Los Angeles County Mental Health System from 1983-1988. It was intended to examine utilization rates, dropout rates (after one session), and treatment outcomes (using pre-and post-treatment Global Assessment Scale scores). Furthermore, we wanted to find out if therapist-client matches in ethnicity and language (a presumed culturally-responsive feature) would be associated with less dropping out and more favorable treatment outcomes. Results indicated that Asian Americans and Mexican Americans tend to underutilize services in comparison with their populations, while African Americans tend to overutilize services. Moreover, dropout rates for ethnic clients were higher (in the case of African Americans) and lower (in the case of Asian

Americans) than for Whites. Interestingly, Asian Americans—especially those who are unacculturated—generally fared better when they saw a therapist who was matched ethnically and linguistically. Similar effects were found for Mexican Americans, although the effects were less dramatic. However, ethnic and language matches were not significantly related to dropping out or outcomes for African Americans and Whites. We do not know why matching is related to outcomes for some groups but not others. The importance of ethnic match may depend heavily on the acculturation level or ethnic-cultural identity of clients. For some clients in the same ethnic minority group, match may be quite important. We do know that ethnic or language matches do not ensure cultural matches which may be of major importance.

We have also examined the outcomes received by ethnic minority clients who use either ethnic-specific services or mainstream services (Takeuchi, Sue, & Yeh, *in press*). The study compared the return rates, length of treatment, and treatment outcome of ethnic minority adults who received services from ethnic-specific or mainstream programs. The sample consisted of 1516 African Americans, 1888 Asian Americans, and 1306 Mexican Americans who used one of 36 predominantly White (mainstream) or 18 ethnic-specific mental health centers in Los Angeles County over a six year period. Predictor variables included type of program (ethnic-specific vs. mainstream), disorder, ethnic match (whether or not clients had a therapist of the same ethnicity), gender, age, and Medi-Cal eligibility. The criterion variables were return after one session, total number of sessions, and treatment outcome. The results indicated that ethnic clients who attend ethnic-specific programs stay in the programs longer than those using mainstream services. The findings were less clear-cut when treatment outcome was examined.

Some studies have demonstrated the value of pretherapy programs that orient culturally-diverse clients to psychotherapy—how it works, what to expect and do, etc. For example, Acosta, Yamamoto, Evans, and Skilbeck (1983) exposed one group of clients to slides, audiotapes, or videotapes to help orient clients to psychotherapy; another group of clients was given a program that was neutral with regard to psychotherapy. Knowledge of and attitudes toward psychotherapy were assessed before and after the programs. Results indicated that exposure to the orientation program increased knowledge and favorable attitudes toward psychotherapy. Therapist orientation programs have also been devised to orient therapists who are working with ethnic minority clients. Reviews of these client and therapist orientation programs have been favorable (see Jones & Matsumoto, 1982).

Let me summarize some of the major findings. First, the quality and quantity of psychotherapy outcome research with ethnic minority clients are problematic. Conclusions cannot be drawn with great confidence. Second, relatively high rates of dropping out from treatment are observed among some ethnic minority groups, especially African Americans. Third, most comparative studies reveal that treatment outcomes for ethnic clients are either the same as, or poorer, than for Whites. No study has demonstrated superior outcomes for ethnics. Ethnic minorities tended at

best to have similar treatment outcomes to White Americans. Fourth, the effectiveness of psychotherapy is complex, requiring more than an affirmative or negative response. If we put aside the subtleties and complexity involved in the question of overall effectiveness, we have some reason to believe that certain conditions are related to effectiveness: Ethnic similarity for clients and therapists of some ethnic minority groups; the use of some culturally responsive forms of treatment; pretherapy intervention with ethnic clients; and the training of therapists to specifically work with members of culturally diverse groups. The most meaningful research, therefore, deals with conditions of effectiveness rather than with attempts to answer the effectiveness question in general. In actuality, the research on culturally-responsive forms of treatment attempts to identify those culturally-derived practices that are beneficial.

Most critics of psychotherapy with ethnic groups do not challenge the value of psychotherapy or psychological interventions. What they often challenge is the outcomes of psychotherapy when traditional psychotherapeutic practices do not consider the culture and minority group experiences of ethnic minority clients. Some may also advocate for prevention and social, political, and economic changes rather than psychotherapy. Nevertheless, few critics would argue that psychotherapy cannot be effective with ethnic minority group clients.

Policy/Psychotherapy Issues

Given the state of our knowledge, should we offer psychotherapy even if effectiveness has not been demonstrated? Should we use treatments if they have not been tested with ethnic minority populations? If we are serious about basing treatment on research findings, what should we do in terms of treatment, if not enough research has been conducted to permit conclusions to be drawn with respect to psychotherapy and assessment with ethnic minority clients? This leads to other questions. Is the lack of evidence over effectiveness attributable to the lack of good research (i.e., if good research were available, effectiveness would be apparent) or to the actual ineffectiveness of treatment? What alternatives are there to psychotherapy?

I raise these questions, not because I have answers but because the science and profession of psychology must address them. However, it does seem to me that we cannot wait for research to always provide answers as to what we should do. As argued in a previous paper (Sue, 1992), I know that many investigators believe that before taking a stance on policy and public interest issues, we should have substantial research justification. Their position is that advocating for programs and policies in the absence of a strong research foundation is irrational and may lead to poor policies and programs. Others, who feel the urgency of addressing public needs for programs and solutions to problems, point out that "Rome may burn while researchers fiddle away."

There is not much disagreement over the critical importance of using research to guide policies and practices. But should we practice or perform treatment in the

absence of definitive research findings? Doing so could result in practices that are driven by emotions rather than reason, or opinion rather than fact. However, what should be done if there are urgent needs for which solutions have not been well researched? Do we suspend actions? This is the case for ethnic minorities for whom no rigorous studies have examined treatment outcomes. Furthermore, what should be done if there are legitimate debates over the conclusiveness of research findings? Smith (1990) maintains that research data on issues are seldom conclusive, and judgements differ as to the threshold for research findings that are considered "definitive."

In addition, it is erroneous to believe that policies and practices are adopted only after solid research justification is available. They may be established because of ethical-moral issues, public opinion, cultural practices, and political considerations. There are also many examples in which convergent and substantial research evidence pointing to a specific course of action exists; yet, the action has failed to be adopted. For example, research has consistently shown that alternative programs for persons with mental disorders are often as effective, and yet less expensive, as traditional forms of care in mental hospitals (Fairweather, 1980; Kiesler, 1982). However, decision-makers as well as the public have failed to implement such alternative care systems. (In my more cynical moments, I believe that human beings have not biologically evolved to the point where decisions can be guided primarily by rational and empirical thinking and where violence and aggression can be avoided.)

As noted in my previous paper (Sue, 1992), perhaps in our debate over whether or not solid data should precede policy recommendations, we have neglected the fact that research is important in all phases of the policy making or maintaining process. This fact implies that the important issue is the intertwining of research with policy and practice, not which comes first. Sometimes, policies and practices may be established for any of a variety of reasons. Research is then initiated to test the outcomes, and the policies and practices are modified or new and often untested practices develop, which are then subjected to research. Thus, the initiation of new and untested therapies and practices can be encouraged without abandoning science. In our bid to link scientific standards to practice, let us not become so single minded that we fail to deal with the consequences of the limitations in our knowledge concerning effective treatments and the fact that the needs of the public may have to be addressed even if our knowledge is limited.

Let me raise some other issues. How far do we go in "what works" philosophy? If we find through our research that certain procedures work with some ethnic minority clients, should we employ the procedures even if they involve spiritualism, faith healing, satanism, or deception? The question is not absurd. I have spent considerable time in various Asian countries. While in Singapore, I was informed by mental health workers that some individuals develop a culture bound syndrome in which hysterical symptoms appear. The afflicted individuals attribute the symptoms to spirits that invade the body after a person has stepped on the "wrong" piece of earth. I asked some of the Western trained psychiatrists how they treat persons with

the disorder. Although they did not believe in the cultural explanation involving spirits, they nevertheless provided treatment (as explained to clients) intended to "rid the body of the spirits" as well as western psychotherapy. Lefley and Bestman (1984) describe their work with different ethnic groups in Miami where mental health professionals collaborate with folk healers or spiritualists who may perform exorcisms. Assuming that one does not believe in spiritual healing (i.e., believe in the supernatural explanation for the outcome), is there anything unethical, dishonest, or disturbing about pretending in front of the client to believe in such treatment?

Finally, can standards be culturally biased? Let me provide some examples of where guidelines and standards appear to have differential cultural implications. In the U.S., we have child abuse laws that help us to determine if adults are acting inappropriately with children. An assumption underlying these laws is that children have certain human rights. In other cultures, the assumption is considerably weaker. Traditionally, in certain Asian cultures, children have very little rights and parents are expected to have much greater freedom in how they treat and discipline children. Some cases have occurred where Asian American parents who been accused of child abuse maintain that it is their right to treat their children as they see fit. As another example in which standards of practice have different cultural implications we can examine guidelines for the providers of care. Guidelines often discourage the receiving of gifts from clients and the development of personal relationships between therapists and clients. Accepting gifts and forming personal relationships can undermine the professional relationship. Yet, the professional and personal roles are often blurred in other cultures. For example, in Chinese culture, clients often give physicians or other service providers expensive or unexpensive gifts as tokens of appreciation or as an encouraged cultural practice. They may also invite the provider to family gatherings as a respected friend or expect the provider to act as a family advisor. If the provider refuses gifts or maintains a formal and distant relationship, clients may lose face and feel rejected.

By raising all of these issues, I am not trying to deemphasize the role of science in practice. For too long, practice has proceeded without research guidance. What I am saying is that perhaps our ideals are now advancing ahead of reality, and issues concerning science and practice cannot be approached in a naive fashion.

Socio-Political Issues

In dealing with ethnic minority issues, research and practice are not just scientific or value-free ventures. There are consequences or side effects to nearly every course of action we can take, because of the history of race relations. There is no question that ethnic minority issues have been controversial. They are attributable to the concepts of ethnicity and minority group status. Differences in ethnicity often results in cultural value clashes, while minority group refers to a status in society—a status accompanied by prejudice and discrimination. The two are often confounded. Differences between ethnic groups are often erroneously attributed to cultural factors and visa versa. For example, traditional Chinese values are often

compared with Western values in order to explain why Chinese Americans may be more likely to show certain attitudinal or personality differences from White Americans. In essence, the two cultures are conceptualized as being orthogonal or independent variables. In reality, the two are interactive and not independent. That is, Chinese Americans have had a long history in the U.S. As members of a minority group who have experienced prejudice and discrimination, their attitudes and behaviors may be a product not only of Chinese culture but also of the history and experiences in this country. Because of this history, research and treatment involving ethnic minorities are embedded in larger issues regarding segregation, discrimination and inequalities, cultural biases, stereotyping, and political correctness. Kenneth Clark (1972) argued that the mental health profession has not been immune to the forces of racism in society and that racism may be reflected in processes such as diagnosis, assessment, and treatment. These two concepts—ethnicity and minority group status—help to differentiate ethnic minority research from cross-cultural research. The former is more likely to involve the two concepts while the latter is primarily concerned with ethnicity. The two concepts also explain why debates over diversity and psychotherapy are far more intense than debates over, say, schizophrenia and psychotherapy.

Moreover, research on ethnic minority groups, especially those that have policy implications, often generate unexpected issues. Our work on psychotherapy and treatment also created controversies. Let me indicate some of the consequences of involvement with ethnic minority issues and then raise some dilemmas for consideration.

An unexpected controversy occurred just a few months ago. One of our early studies (Sue, 1977) indicated that ethnic minority clients tended to drop out of treatment rather quickly. This led us to examine whether drop out rates were lower when clients saw therapists of the same ethnicity (Sue et al., 1991). The findings were clear in that ethnic match was associated with lower drop out rates. We felt that ethnic match was therefore beneficial. However, ethnic matches were also associated with more treatment sessions. When I presented the results of the study at a meeting with directors of NIMH funded ethnic minority research centers in 1994, James Jackson, a close friend of mine who directs the African American Mental Health Center at the University of Michigan, brought up an interesting point. He noted that the greater number of sessions, the costlier the treatment. Therefore, the association between ethnic match and increased numbers of treatment sessions could be used to argue against matching because match appears to increase the cost of treatment. This is a particular problem because superior outcomes for ethnically matched dyads could not be demonstrated in a clear manner. That is, the outcome measure was rather weak and ethnic match and treatment outcome were related only for certain, and not all, groups. Other dilemmas are also apparent in the following situations:

1. Several years ago, the Committee on Psychological Tests and Assessment was reviewing guidelines on assessment and sought input from various APA divisions and governance agencies. In attempting to see that assessment procedures would not

be culturally-biased against ethnic minorities, the Committee dealt with a proposal indicating that if clinicians were not competent to conduct a psychological evaluation of an ethnic minority client—presumably because of cultural unfamiliarity—they should avoid making an assessment. One can imagine a similar proposal concerning psychotherapy—that clinicians whose competence with ethnic clients is in question should not provide clinical services. Obviously, it would be inappropriate to subject ethnic minority clients to inadequate services. On the other hand, in the attempts to see that clients are not given inappropriate services, I raised several questions. If the proposal is adopted, what would prevent clinicians from discriminating against ethnic clients? Who is going to serve ethnics? Don't we have the responsibility not only to decline from providing services to which we are not qualified but also to see that services are available to all? In the attempt to be culturally-responsive, a more fundamental issue concerning the availability and accessibility of services was overlooked. It seemed to me that while the underlying principle was appropriate, detrimental side effects could follow. In practice, we needed to also specify, and to have available, services for the entire population.

2. In advocating for mental health services for diverse populations, I recommended that ethnic specific services be created (see Sue, 1992). This recommendation involved the creation of mental health programs/centers or sections of hospitals that would specifically serve targeted ethnic minority populations. The recommendation made sense to me because in some communities there was a heavy concentration of members of a particular ethnic group. Having services that could cater to this group—e.g., bilingual/bicultural service providers, notices and announcements written in the ethnic language of the group, an atmosphere ethnically-consistent with the community, etc.—seemed important. However, some argued that ethnic specific services would perpetuate segregation and rather than having special services for ethnic minorities, the mental health system should be designed to effectively serve all groups (Kramer, 1984). In principle, I agreed with the need for integrated services. However, I did not believe that in the near future, this goal could be attained, given patterns of ethnic residential segregation and lack of research over the effectiveness of services for all populations.

3. Ethnic matching of therapists and clients has also provoked much discussion. As mentioned previously, our studies revealed that ethnic match may be beneficial for some kinds of clients. The findings bolstered the fact that ethnic diversification of service providers is important, in order for clients to find ethnically similar therapists. However, they also raised unanticipated issues. For example, after I gave a talk on the research at the 1994 Congress meeting of the International Association of Applied Psychology in Spain, a member of the audience informed me that some in South Africa were using my research to justify having "Whites taking care of Whites and Blacks taking care of Blacks." Again, I was confronted with the segregation issue. My position is not that ethnic match should always take place, that ethnic mismatches cannot be beneficial, or that individuals cannot be trained to effectively work with diverse client populations. Rather, our mental health ideals

have implicitly promoted freedom of choice in the matching of therapist and treatment approach with the client. Such choices are often based on client perceptions of the therapist's effectiveness, rapport, and understanding. I believe that matching and ethnic-specific services are consistent with freedom of choice and effectiveness of treatment. If clients need or want therapists of the same ethnicity, such therapists should be available.

4. The outcomes of research findings have often created problems and dilemmas. Our Seattle project (Sue, 1977) found a high drop out rate for ethnic minority clients undergoing treatment. We felt that services were not meeting the needs of ethnic minority clients. After some of the results were published, and without our knowledge, the National Institute of Mental Health, which funded our research, contacted the Washington State Department of Social and Health Services (DSHS) in order to express its deep concern over the inequities in service delivery that were demonstrated by our project. Reacting to this concern, DSHS apparently became worried over the possible adverse public reaction to the findings and over the criticisms from NIMH which could jeopardize future State funding opportunities from NIMH. It then challenged the validity of the findings by arguing that one of the 17 mental health facilities included in the study might not have provided accurate data. Thus the State raised some doubt over the validity of the data that it had supplied us.

Again, these events occurred without my knowledge. It was not until I was asked by the Washington State Psychological Association to testify at a senate subcommittee hearing that the controversy was explained to me. In preparation for the hearing, I reanalyzed the data. By excluding from the reanalysis the one facility in question, we found that our original conclusions were valid. Even though I was gratified that the findings did not essentially change, I had strong and mixed feelings over the situation. I wanted to use the findings to find out what the status was of various ethnic minority clients who used mental health services and to make policy and practice recommendations in order to improve services. However, in the process, the State of Washington was being singled out for criticism. I was concerned that the State was being subjected to criticism when other states and systems were encountering similar problems in responding to ethnic minority populations. Then too, the State had provided us with the data as a cooperative research partner and as a goodwill gesture (at our request). Given our experience, I was worried that other states and mental health systems programs might be reluctant to allow researchers access to their data, which could be used to criticize their mental health practices.

Fortunately, two positive outcomes emerged after my testimony. First, officials from the State indicated their concern over the delivery of services to all clients and told me that they would be willing to collaborate on research in the future. Secondly, over the years, the State made some firm commitments to offer culturally-responsive services. It then conducted a follow-up investigation of our Seattle project. The study found that the high dropout rates for ethnic minority clients had now been reduced and that the mental health system had hired more ethnic minority service providers,

created more ethnic specific services, and established other innovative programs to serve ethnics (O'Sullivan, Petersen, Cox, & Kirkeby, 1989).

The point I am making is that as scientists whose works have practice and policy implications, we must be cognizant of the potential dilemmas that may well emerge when dealing with diversity issues. We must prepare ourselves for several circumstances when bringing research to bear on these issues. First, the complexity of issues must be recognized. Many of our actions that are based on research have side effects, so that actions to promote multiculturalism may be beneficial at one level but harmful at another level. Second, it may not be possible to avoid the side effects of programs and policies that we undertake. In this case, there must be conscious and deliberate decision-making that considers costs, benefits, principles, realities, and ultimate goals that we have with respect to diversity. It is through this process of deliberation that a more coherent approach to diversity can emerge. Third, conflicts often cannot be avoided when we attempt to apply scientific standards to clinical practice. Fourth, cultural diversity is the nature of human beings, and it should be the nature of our science and practice of psychology.

Implications for Psychotherapy and Research

Psychotherapy

We must provide effective services to ethnic minority groups. In view of the fact that little empirical evidence exists concerning the effectiveness of treatment and the conditions that promote positive outcomes among ethnic minority clients, it would be unwise to set precise guidelines on how to conduct psychotherapy with these clients. Nevertheless, we can hypothesize, or speculate on, general processes or conditions that may be important. First, ethnicity, culture, and minority group status are important concepts for psychotherapists who work with ethnic minority clients. The available evidence suggests that therapists should be prepared to deal with these concepts and issues with their clients. Cultural issues may not be salient to all ethnic clients in all situations. Nevertheless, therapists who are uncomfortable with cultural issues are limited when their clients raise ethnically pertinent topics in therapy. Therapists should become knowledgeable about the cultural background of ethnic clients and be adept at working in cross-cultural situations.

Second, having available a therapist of the same ethnicity as the client may be advantageous. While ethnic matches are not necessary for positive outcomes, there are times in which certain clients may prefer or work better with an ethnically-similar therapist. Having bilingual and bicultural therapists is vital to those clients who are recent immigrants and who are not fully proficient in English. The problem is that ethnic clients often have little choice, unless we have available more ethnic minority, bilingual, and bicultural therapists.

Third, therapists who are unfamiliar with the cultural backgrounds of their clients may want to consult with mental health professionals who are knowledgeable of the clients' culture. Receiving training in working with culturally-diverse clients

is also recommended. It is difficult to be fully proficient in working with many diverse groups. Assistance should be sought in the assessment or treatment of any client whose cultural background or lifestyle is unfamiliar to the therapist or markedly different from that of the therapist.

Fourth, culture-specific treatment should be available to ethnic clients, especially those who are unacculturated or who hold very traditional ethnic values that are discrepant from Western values. As mentioned previously, many researchers have argued that such treatment is valuable and beneficial.

Fifth, for clients who are unfamiliar with Western psychotherapy, some sort of pretherapy intervention may be important. Before therapy, clients should receive some knowledge of what psychotherapy is, what roles clients and therapists adopt, what to expect in treatment, and how treatment can affect mental disorders. Similarly, efforts should be made to educate community groups on how to recognize emotional disturbance, what to do with someone who is disturbed, what mental health services are, and how to use services. Issues of confidentiality, client rights, etc., should also be presented to the community. These strategies increase the likelihood that ethnic clients will better understand treatment and will reduce feelings of strangeness in the role of a client.

Research

The greatest obstacle to having science play a major role in determining psychological practice with ethnic minority populations is the lack of research rather than the lack of appreciation for science. As mentioned earlier, not a single rigorous study exists that convincingly demonstrates the efficacy of psychotherapy with these populations; while inferences can be drawn about the conditions that promote psychotherapeutic effectiveness, little programmatic research is available. Furthermore, few studies have examined the cross-cultural validity of assessment measures. In the absence of research on ethnic minority populations, practice and recommendations for therapists and assessors have been guided by folk wisdom, intuition, experiences, and "best guesses."

Despite the lack of research, ethnic and cross-cultural research is important not only to guide practice but also to enhance science. Let me try to indicate what can be accomplished by ethnic minority/cross-cultural research.

1. Cross-cultural and ethnic research is invaluable in improving research designs and in testing the generality of theories. Cross-cultural research can be used to increase the range of variables of interest. For example, if one wanted to study the personality variable of collectivism versus individualism, a greater range on the variable can be achieved if the study were conducted among both individualistic (e.g., American) and collectivistic (e.g., Taiwan) societies. In addition, a researcher who conducts research in different societies can establish the validity of the theory for human beings (and not simply for one's own culture), as noted by Triandis and Brislin (1984). For example, some researchers have identified five, orthogonal personality factors (i.e., the Big Five) that have been consistently found to underlie

personality attributes in research spanning more than half a century, primarily in the U.S. (Wiggins & Picus, 1989). Is the Big Five germane to nonWestern cultures? Bond and Yang (1990) have found some evidence that the Big Five is applicable in Chinese culture but also that some differences are apparent between the Big Five and the underlying personality factors in Chinese culture. What is interesting to explore is whether there are personality dimensions in other cultures that are more salient than those in the Big Five. For example, Zane (1991) has developed a measure of loss of face which is a very important construct in Chinese cultures. Loss of face is the threat to, or loss of, one's social integrity. Zane is studying whether this personality variable—loss of face—can supplant any of the ones in the Big Five in term of saliency for the Chinese. If so, then the Big Five is not universal in its saliency.

2. Limitations in our practices can be determined. Traditionally, western psychologists have studied the efficacy of different treatments on the same population or the efficacy of one treatment with diagnostically different clients. Strangely, we have largely failed to study the effectiveness of treatment with different ethnic populations; and yet, such studies are needed to demonstrate the generality of treatment effects and the potency of the treatment. Instead of always comparing different treatments on similar populations, we should also use one treatment and test different populations. Why have we not done this?

3. A related point is the need to study individual differences and heterogeneity among members of ethnic minority groups. For example, our work previously cited have demonstrated that the effects of matching the ethnicity of therapists and clients depend on individual difference variables. Research on individual differences can address the question of whether there universals in psychotherapy. That is, what psychotherapy principles, tactics, or processes appear to effectively cross cultures?

4. The principles that govern diversity and its effects should be studied. What aspects of culture is important in psychotherapy? We can assume that some cultural features are more important than others in psychotherapy. For example, we have hypothesized (and are now testing) that how a client conceptualizes mental disorders, what goals are deemed appropriate, and what means are used to resolve problems are especially important in the therapeutic relationship. By trying to determine the underlying principles, we can determine what aspects of culture are important for the clinician to consider.

In this chapter, I have tried to indicate some of the diversity or ethnic implications that emerge when we try to link scientific standards to clinical practice. There is no question that practice should be guided by research. My plea is that we conduct more ethnic research so that a meaningful relationship between science and practice can be achieved and that we become aware of, and deal with, controversies that inevitably arise whenever ethnicity is discussed.

References

- Abramowitz, S. I., & Murray, J. (1983). Race effects in psychotherapy. In J. Murray & P. Abramson (Eds.), *Bias in psychotherapy* (pp. 215-255). New York: Praeger.

- Acosta, F. X., Yamamoto, J., Evans, L. A., & Skilbeck, W. M. (1983). Preparing low-income Hispanic, Black, and White patients for psychotherapy: Evaluation of a new orientation program. *Journal of Clinical Psychology*, 39, 872-877.
- Brown, B. S., Joe, G. W., & Thompson, P. (1985). Minority group status and treatment retention. *International Journal of the Addictions*, 20, 319-335.
- Cattell, R. B. (1947). Confirmation and clarification of primary personality traits. *Psychometrika*, 42, 402-421.
- Clark, K. B. (1972). Foreword. In A. Thomas & S. Sillen (Eds.), *Racism and psychiatry*. New York: Brunner/Mazel.
- Fairweather, G. W. (Ed.). (1980). *The Fairweather lodge: A twenty-five year retrospective*. San Francisco: Jossey-Bass.
- Griffith, M. S., & Jones, E. E. (1978). Race and psychotherapy: Changing perspectives. In J. H. Masserman (Ed.), *Current Psychiatric Therapies: Vol. 18* (pp. 225-235). New York: Grune and Stratton.
- Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research, and Practice*, 15, 226-236.
- Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology*, 38, 722-731.
- Jones, E. E., & Matsumoto, D. R. (1982). Psychotherapy with the underserved. In L. Snowden (Ed.), *Services to the underserved* (pp. 207-228). Los Angeles, CA: Sage Publications.
- Kiesler, C. A. (1982). Mental hospitals and alternative care: Non-institutionalization as a potential public policy for mental patients. *American Psychologist*, 37, 349-360.
- Kramer, B. M. (1984). Community mental health in a dual society. In S. Sue & T. Moore, (Eds.), *The pluralistic society: A community mental health perspective* (pp. 54-262). New York: Human Sciences Press.
- Lefley, H. P., & Bestman, E. W. (1984). Community mental health and minority: A multi-ethnic approach. In S. Sue & T. Moore (Eds.), *The pluralistic society: A community mental health perspective* (pp. 116-148). NY: Human Sciences Press.
- Lerner, B. (1972). *Therapy in the ghetto: Political impotence and personal disintegration*. Baltimore: The Johns Hopkins University Press.
- O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology*, 17, 17-30.
- Parloff, M. B., Waskow, I. E., & Wolfe, B. E. (1978). Research on therapist variables in relation to process and outcome. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.) (pp. 233-282). New York: Wiley.
- Query, J. M. N. (1985). Comparative admission and follow-up study of American Indians and Whites in a youth chemical dependency unit on the North Central Plains. *The International Journal of the Addictions*, 20, 489-502.

- Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research*. Malabar, FL: Krieger Publishing Company.
- Sattler, J. M. (1977). The effects of therapist-client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 252-290). Elmsford, NY: Pergamon.
- Smith, M. B. (1990). What have we done? What can we do? *American Psychologist*, 45, 530-536.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32, 616-624.
- Sue, S. (1992). Ethnicity and mental health: Research and policy issues. *Journal of Social Issues*, 48, 187-205.
- Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59, 533-540.
- Sue, S., Zane, N. W. S., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change, 4th edition* (pp. 783-820). NY: Wiley & Sons.
- Szapocznik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vazquez, A., Hervis, O., Posada, V., & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Counseling and Clinical Psychology*, 57, 571-578.
- Triandis, H. C., & Brislin, R. W. (1984). Cross-cultural psychology. *American Psychologist*, 39, 1006-1016.
- Wiggins, J. S. and Picus, A. L. (1989). Conceptions of personality disorders and dimensions of personality. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 305-316.
- Yang, K., & Bond, M. H. (1990). Exploring implicit personality theories with indigenous or imported constructs: The Chinese case. *Journal of Personality and Social Psychology*, 58, 1087-1095.
- Zane, N. W. S. (1991, August). *An empirical examination of loss of face among Asian Americans*. A paper presented at the 99th annual convention of the American Psychological Association, San Francisco, CA.

Footnote

The writing of this paper was supported by NIMH Grant R01 MH44331.